

THE NEED FOR A CHILD GUIDANCE SERVICE.*

By MARY C. LYDON.

Introduction.

IN introducing the subject of child guidance I feel conscious of a grave responsibility to the children of the country, to those of the well-to-do as well as those of the poor, for psychological problems abound in all grades of social life. I regard it as grave because upon the manner of its presentation and appeal may rest the effectiveness of the endeavour to enlist the co-operation of the profession in the drive to get child guidance established here as in the United States of America, Great Britain and on the Continent.

It has been said that a nation's only real wealth is her children, and while in Dublin, with well-staffed and well-equipped children's hospitals, efficient child welfare and ante-natal clinics and comprehensive school medical service, we have been discharging our duties towards them in all things pertaining to their physical well-being yet we are a quarter of a century behind other countries in taking cognisance of those factors that make for healthy psychological development and subsequent well-balanced, self-confident maturity.

Child guidance is established to promote the study of behaviour in childhood and to encourage by medical, social and educational treatment the prevention and amelioration of the neuroses, behaviour-difficulties and all nervous disorders. It is an attempt to bring together the various resources of the community on behalf of children who are in distress either through parental or other adult lack of understanding of their emotional needs or because of maladjustment to their environment. Such children often show peculiar character traits, anti-social proclivities, or an inability to fulfil the demands made on them either at home or at school.

The evolution of child guidance dates from approximately 1912, when Dr. William Healy, in the course of his researches in the field of juvenile delinquency at the Juvenile Psychopathic Institute of Chicago, became convinced that the subject of child behaviour was so vast, and behaviour itself had so many facets, such extensive roots and ramifications, and was subject to so many and varied influences, both innate and external, that no single individual could carry through child guidance efficiently for even a small community. In view of this he acquired the services of two others—an educational psychologist to test and assess the intelligence quotient and a trained social worker with special psychiatric qualifications to sift the environmental influences contributing to each problem. Public authorities in America, quick to see the advantage to youth and the State which Dr. Healy advocated, soon came forward with a scheme for the service which in 1922 became known as the Child Guidance Clinic.

Some years later Dr. William Moodie introduced child guidance

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methods in England and, after a struggle, succeeded in establishing at Islington a clinic which is still known as the London Child Guidance Clinic. This clinic was temporarily situated during the war at Woodside Hospital, Muswell Hill, N., under the directorship of Dr. Kathleen Todd during Dr. Moodie's absence. Many of the personnel, child psychiatrists, child psychologists and psychiatric social workers have been trained there for the staffing of provincial clinics as these became established.

First Hospital Clinic.

On January 13th, 1930, the first Child Guidance Clinic to form part of a voluntary teaching hospital was inaugurated at Guy's. The success of this clinic needs no elaboration. It was under the directorship of the late R. D. Gillespie, and its success, as well as that of the entire Psychological Department of Guy's, which today places that hospital in the unique position which it enjoys in the field of psychological medicine is to a great extent due to the personality, as well as the teaching of this great man. Guy's is also a training centre for child psychiatrists, and fortunately for me, it was one of the centres to which I was sent for my Fellowship training by the London Council of Child Guidance. Here I worked for just over a year under Dr. Gillespie and Dr. Felix Browne, his Deputy Director, acquiring the technique of investigation, treatment and administration, and hoping that one day soon we would have a similar service established here in Ireland.

Whenever a new organisation is instituted to deal with an old problem there are people who express their doubts about the genuineness of the need for which it caters. This is particularly true of the Child Guidance Movement. The clinic at Guy's was such a complete answer to these doubts that many of the children's hospitals soon formed their own Child Guidance Unit. Notable amongst these were the hospitals at Great Ormond Street and Paddington Green, where later the service was extended to the provision of in-patient facilities for observation and treatment.

A clinic which forms part of a children's hospital has many advantages, chiefly in that it has the services of specialists in all branches of medicine and surgery and the risk is thus minimised of over- or under-estimating the importance of physical factors in personality disorders. It can be run more economically since the expense of premises, fuel, lighting, cleaning and caretaking is obviated. Furthermore, it opens up opportunities for the study of prophylactic measures for diminishing the incidence of neuroses and even of psychoses in adult life.

A Specialised Service.

Child guidance is a specialised service demanding highly trained personnel and is, therefore, relatively expensive, though not so expensive in the long run as neglect of the symptoms with which it is competent to deal. Proper selection of cases for investigation is important to avoid waste of time, and the responsibility for this selection rests with pediatricians, general practitioners, school medical officers, head teachers, juvenile court magistrates, youth leaders and such people.

It will thus be seen that only persons who are trained and experienced in child guidance work are capable of dealing with the difficult and delicate situations that arise and, for this reason, the National Provisional Council of Mental Health in England have set down the essential qualifications of the staff of a clinic as follows:—

1. *A child psychiatrist.* A man or woman with a medical degree and the Diploma in Psychological Medicine: experience in a mental hospital; training in dealing with psychoneurosis in adults; experience with sick children and with normal children and special training in child guidance.

2. *A child psychologist.* A man or woman who has an honours degree in Psychology or its equivalent; experience with children in teaching; a knowledge of educational methods followed by training in intelligence testing and child guidance team work in a clinic.

3. *A psychiatric social worker.* A man or woman holding a Social Science Certificate or a recognised equivalent with training and experience in social work, followed by the Certificate of Mental Health.

These three constitute the essential team operating a clinic. Play and speech therapists are further developments in large clinics. The former deputises for the psychiatrist in supervising group-play, when children have reached a stage of adjustment which no longer calls for individual play therapy, while the latter attends to the considerable number of speech defect cases—chiefly stammerers—who have been referred.

Individual Duties. The psychiatrist, who is known officially as the Medical Director, gauges the child's temperament and his attitude to those with whom he lives and associates, and uncovers the underlying reason for the behaviour which has brought him to the clinic. During the initial interview, which takes approximately one hour and a half, he makes the physical examination and sets out to establish a good relationship with his little patient. This is more or less easily accomplished, depending on the doctor's ability to adapt himself to the varying situations of an hour in the play-room with a child who has hitherto proved to be difficult and inaccessible. He is thus enabled to make a diagnosis and to formulate the line of treatment calculated in his opinion to evoke the best response. He interviews the parents and takes a detailed personal and family history. He observes their attitude to the child and his problem and is able to make a fair estimate as to whether the patient's neurosis has been inherited, communicated or acquired through external influences. To give him a line on his advice to the parents he has the psychiatric social worker's report on the home situation, the school report and the psychologist's estimate of the I.Q.

Further therapeutic interviews of approximately one hour's duration take place with the child at weekly intervals at the clinic, while a close touch is kept with the home and parents and also with the school in order to gain the co-operation of all concerned in the treatment. Much of this work with the family and environment is done by the psychiatric social worker, who also interviews parents while the psychiatrist is with the child.

When the problem is connected with the child's school life the educational psychologist takes a leading part in the line of treatment.

In cases where, owing to intellectual limitations, not amounting to mental defect, he cannot cope with his classfellows in school work, she does special coaching, and the improvement in the child's prestige with teacher and classfellows which follows from better school work goes far to establish his self-confidence and security.

Variability of Reaction.

A child reacts to an educational problem in a variety of ways. For example, if his is a sensitive nature and he is made painfully aware of his limited ability by punishment or taunts he becomes shrinking and introverted. Solitary and driven to phantasy for relaxation, he pictures himself a great man, brilliant and clever, and so, to phantasy he retreats with increasing frequency as he grows older. Herein is the seed of a schizophrenic psychosis if his problem remains unrecognised and no effort is made to allow for his limitations or to exteriorise him and keep him in close touch with reality. Again, given the same intellectual handicap and the same school conditions, an aggressive type of child will react with calculated mischievousness and unmanageability. He may deliberately distract and torment his schoolmates at their work and punishment is no deterrent; or, to get his own back, he may play truant, join a gang and become delinquent. This is a common sequel of failure at school. Yet another child struggles to keep up with the class—works too hard—sleeps too little—gets anxious and worried and develops tics, habit spasms, obsessions. Here is a condition which, if unrecognised and untreated, determines a later anxiety state or perhaps even an immediate nervous breakdown.

Another kind of educational problem is the child who is perhaps very clever but who is inhibited by an unsatisfactory emotional relationship with a teacher for whom he cannot do justice to his ability. The teacher attributes the inferior work to laziness or stupidity, and so the situation becomes worse until brought to light.

The socialisation of all such children is undertaken and is done through the medium of youth clubs, Scouts, Guides and such organisations whose co-operation is most valuable and attainable. This work comes within the duties and scope of the psychiatric social worker.

In all cases where the problem is educational the psychologist makes personal contact with the head teacher and helps him to an understanding of the child's difficulties. She acts as a link between the school and the clinic, making for fuller co-operation from the teachers both in the referring of children for investigation and in the carrying out of suggested adjustments in the child's school life. This is important, as teachers are often the first to notice deviations from the normal in children's behaviour.

Clinical Work.

At the clinic, therefore, the fundamental causes of all problems and nervous manifestations in children are investigated and an effort made to modify or eradicate them by treatment rather than to control them by the imposition of authority. It is a routine procedure to do a full psychological test on all cases referred and the psychologist submits the

record booklet, with her remarks on the child's reaction to the test situation, to the psychiatrist before the latter sees the case. When mental defect is the condition (I.Q. below 70), little can be done in the absence of special schools except suggestions for environmental adjustments or institutional care. States of anxiety, hysteria, fears and obsessions, tics and habit spasms, stammering, feeding and sleeping difficulties, enuresis, jealousy, temper tantrums and many other like symptoms of personality disorder usually respond favourably to treatment, which may take the form of play therapy in young children, or direct psychotherapy in pre-pubertal and adolescent stages—combined, in all cases, with education of the parents and the necessary environmental modifications. Whichever method is used, its aim is to allow the child to express the frustrated desires and dimly realised needs which have been kept in the background of his consciousness through force of circumstances, but which continue to demand satisfaction and, through the disturbance they create, affect the even tenor of thought and conduct.

Play Therapy.

The technique of play-therapy is difficult to describe, since every case proceeds along individual lines and not according to any preconceived plan. It is full of surprising turns and depicts many changes of mood and theme before the problem is finally played out. It is suitable for all children under 12 years. Between the ages of 3 and 8 they enjoy primitive materials like sand and water, and the older ones fashion battlefields and desert camps, farms and zoological gardens, villages complete with church and shops, bits of coast line with cliffs and sea and small boats—all on large sand-trays. They revel in the multiplicity of things they can make and do by combining the miniature figures, trees, animals and implements with which the playroom is well stocked. Apathetic children develop a keen interest, and often eventually show great ingenuity in making different sand pictures each day. The younger ones build sand castles, make "big seas" and sail small boats thereon. They drown in the sea small figures representing a new baby brother or sister, an offending parent, relative or other child who has aroused their emotions of fear, anger, jealousy or hatred and who is thus related to their problem. Others make mud pies and what they call "a lovely mess"! Most small children like to play with running taps. Little girls play families with dolls and prams, houses and furniture, shops and money and they often play out the situations prevailing in their own homes, but modified into what they would wish them to be rather than what they are. They often play out the school situation in which the psychiatrist is always the pupil and the patient the teacher who administers sharp rebukes, slaps, or orders to stand in the corner for various misdemeanours. They like to draw and colour their pictures and their prevailing mood is fairly easily interpreted in this way. At Guy's or the Maudsley Hospital Clinics we were not encouraged to interpret drawings or play symbolically as was done by earlier workers of the Freudian school, for experience had proved that the act of self-expression through play and pictures and the playing out of situations to an understanding and sympathetic adult without fear

of criticism or ridicule, and without any interpretation to the child, was therapy in itself, and he got well of whatever he had been referred for.

Clinical Examples.

M.S., a shy, inhibited boy of 7 under my care at Guy's, had perfect manners and spotless grooming, a pale face and a tendency to frequent colds and other minor physical ailments. He was obviously cuddled, had food fads and fears of the dark. His mother was a fussy, over-protective little person who worried about him and so increased his troubles. During the first few sessions he refused to play with sand and water for fear of soiling his hands and clothes or of getting wet. He just put the toys up in an orderly fashion in neat rows, showing a degree of obsession as well. Sometimes he did drawings and coloured them with poster paints. All of them lacked vitality and aggressiveness and represented houses with a garden and flowers, and clothes hanging neatly on a line to dry, or a village with a church and spire, but no sign of life appeared in any of them. His emotional development was confined within very narrow limits, but all this time he was reacting slowly but surely to a new experience. Here was a grown-up person who was really interested in him, who understood him and answered his questions directly, and allowed him to do just what he liked during his play hour. Gradually after weeks he began to play more aggressively, to talk freely and to climb on playroom furniture, jumping off and making a lot of noise. Later we played variously at being Red Indians and cowboys, when he lassoed me with shouts of triumph from his seat on the rocking horse. Meanwhile he made sand castles with his hands and wiped them on his pullover and got his shirt sleeves wet without misgiving—or subsequent ill-effects.—His mother told the Psychiatric Social Worker that he did not get so many colds and had not missed a day at school since coming to the clinic. He played with the other children of the district, was out of doors except during school hours, and she could scarcely get him in at bedtime. He ate his meals without any fuss and seemed hungry for them. Needless to say, all this did not happen at once. The boy was about four months attending the Clinic for play therapy while his mother was also being helped and advised dealing with him and also about many other problems that had beset her concerning the family and the home.

At the Maudsley, I treated a boy of 8 whose mother said he had such temper tantrums that all the neighbourhood heard his screams and some had even accused her of ill-treating him. He was an only child, but when he was 4 she and her husband had adopted the baby girl of a dead relative. Raymond did not know this and thought she was his sister, but he was rude and vicious to her and, when in one of his tantrums the baby had to be protected. At other times he was good to her and seemed sorry for his bad temper. Her husband, a merchant seaman, had been away nearly three years. After he had left home Raymond had fretted, developed glands in his neck and had been operated on and he was much more difficult since he left the hospital. There were no complaints from school. There was no history of previous serious illness or trauma and developmental milestones were normal. There was no history of mental abnormality in the family, but obviously the mother herself was nervous, anxious and irritable.

On physical examination the boy was tall, under-nourished and pale, but otherwise normal. I.Q. 1012. He talked freely and made himself quite at home in the playroom. He drew a picture of a German bomber dropping bombs and a British anti-aircraft gun scoring a direct hit, the bomber hurtling down in a thick black cloud of smoke that completely dominated the picture. He said he liked school, but at home Gillian, his sister—not his real sister but one Mum had got in Wales when she was a tiny baby—well, she was rather a nuisance! When he plays with his toys she demands them or snatches and often breaks them. He smacks her and then Mum blames him and sends him to bed and won't allow him to stay up to listen to "Monday Night at 8" (a particular radio programme then popular). She takes Gillian on her lap and gives her most of the sweet ration to stop her crying. "I'm very fond of Gillian really and I am always sorry when I hurt her—I am!" At the next session, when he and I had become very good friends, he asked me if he might bring Gillian next time to play with the toys. I thought it would be a very good idea, as I was anxious to see this Gillian person who was such a cuckoo in the nest. When she came she proved most provocative, ordered him about the playroom, made him remove her hat, coat and gloves and hang them up, spilt his poster paints over his drawing and later, when he was making a smuggler's cave with the sand she told him not to do it, but as he continued, unheeding, she went off and told the tale to their mother.

All this time he was incredibly patient and sweet to her. Later, when talking to the mother, she told me that a year previously Raymond had brought her a Nursery School prospectus and had handed it to her without comment! She had not, of course, interpreted the motive, but it was not difficult to see why he had now asked permission to bring the child to the Clinic. It was his appeal for justice and understanding and originated at the unconscious level. His protestations of affection and his sharing

with her of the delights of the playroom were a conscious effort to compensate for vague feelings of guilt for an unconscious hatred. This was his conflict, and the temper tantrums his neurosis. It was simply explained to the mother that it was a jealousy situation which was quite natural, but which was intensified and prolonged by unwise handling on her part and by his father's absence from home. His emotional needs were not being supplied and he had a consequent sense of frustration and insecurity. His neurosis was a protest against the advent of the baby whom he had known all the time to be a stranger, and who had taken some of the love that ought to have been all his own. She was advised to show the boy more love and to appeal to his manliness to take care of her and Gillian, as he was the head of the family until his Daddy came home. Well, the boy improved as the weeks passed and he was transferred from individual to group-play, but one day his mother told me she felt apathetic and depressed and that life was almost too much for her nowadays. On investigation of her own childhood I found she had always been completely dominated by her mother who had sold her house and come to live with her when she married. Her mother now pleads age and infirmity to keep her always by her side, and there was no relaxation from the protracted strain of entire responsibility for the home and the children. It was a syndrome frequently seen in wartime England, but intensified by prolonged separation from her husband and conflict in regard to her mother. It was now possible to see more clearly further causation for Raymond's behaviour, in her own irritability towards him and in her unconscious reproduction through him of her own restricted childhood.

I was able to help her a good deal by these interpretations, and the boy continued to improve. She never missed a week at the Clinic and later, when her husband returned she brought him along and told him it was the Clinic that had saved them and kept them together. It was gratifying to us to feel that we had helped them to find their ultimate happiness.

Notre Dame.

On October 4th, 1943, the Notre Dame C.G.C. was opened in Liverpool, and I had the good fortune to be appointed Medical Director. The experience was a most valuable one, not only because it was a lesson in inauguration, but also because I was obliged to rely on my own experience for diagnosis and treatment.

We had a complete staff of fully-trained personnel, including speech and play therapists and we were financed by the Liverpool Catholic Children's Protection Society. We were given a grant of £300 p.a. by the local education authority for the investigation of cases referred from the schools, including treatment for dull and backward children and borderline cases, and for the diagnosis of mental defect and advice on the disposal of the latter.

During the first six months we dealt with approximately 200 cases. These were referred from school medical inspections, juvenile courts, children's hospitals, approved schools, and even parents themselves brought their problem children. This clinic has the distinction of being the first all-Catholic one in England, but we had up to 40 per cent. non-Catholic patients. The first in Scotland was established about 1933 by a nun, Sr. Marie Hilda, of the Notre Dame Order. This was at Dowan Hill, Glasgow, and is one of the best-known clinics in Great Britain.

Education in Mental Hygiene.

Child guidance endeavours to educate parents and children who are old enough in the supreme value of mental health and the best means of cultivating psychological maturity and stability by which the incidence of adult mental disorders may be diminished. Such education might well take the form of (1) talks at ante-natal clinics on the healthy mental dispositions of pregnancy and motherhood; (2) talks to mothers

at child welfare centres on the emotional and disciplinary needs of their children from birth to 5 years, and (3) talks to parents, teachers, youth leaders and all others interested in the welfare of youth, on the psychological stresses to which the present educational system exposes school-going children during their most impressionable years, and on the general psychic turbulence of adolescence, when libido is augmented and life is surging around them like a swollen river, an ever-increasing threat to their ideals and to their security.

This is a period of great unbalance, and although adolescents sometimes cause much anxiety, at no other time of their lives are they more capable of nobility of purpose, self-sacrifice and devotion.

Conclusion.

Since Child Guidance is a service for children it naturally finds its best place under an authority whose primary work lies with children, such as the child welfare and school medical branch of Public Health. It should have the closest possible association with all other health services since mental and physical health are so closely inter-related.

Recently a new impetus has been given to the development and maintenance of child health, and I venture to hope that it is a propitious time to put forward the claim of the child for treatment as a psychosomatic whole, as a human being with a mind and body which interact upon each other in such a way that they cannot possibly be divorced from each other either in diagnosis or treatment.

It is agreed that "clinical service for child guidance gives effect to the best current thinking about the way to prevent delinquency and mental disease" (Stephenson and Smith, 1934) and, as a recent contribution to the *Journal of the Medical Association of Éire* disclosed, there are well over a million pounds spent annually in Éire in the upkeep of mental hospitals alone it seems as though the institution of such a service as child guidance is one of our most urgent needs. Again, it is estimated that for every £1 spent on child guidance at least £10 is saved the public purse in making institutional or other provision for the psychological disorders of adults, but even if this point had not been proved it is, I submit, an essential duty of the State to establish child guidance centres, and so to help the nation's children to attain well-balanced, self-reliant and healthy maturity.

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